Covered Services and Limitations (RTS)

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Covered Services and Limitations (RTS)

The Virginia Medicaid Program covers a variety of behavioral health treatment services under the Addiction and Recovery Treatment Services (ARTS), Community Mental Health Rehabilitation and Psychiatric Services benefits for eligible members. This chapter describes these services and the requirements for the provision of psychiatric residential treatment and therapeutic group home services.

All psychiatric residential treatment facility and therapeutic group home providers are responsible for adhering to this manual, available on the DMAS website portal, their provider contract with the MCOs, MMPs and the BHSA and state and federal regulations.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at: https://www.magellanprovider.com/MagellanProvider.

Behavioral Health Services Administrator (RTS)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and administration of the behavioral health benefit programs under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a provider network; render service authorizations; adjudicate and process claims; gather and maintain utilization data; reimburse providers; perform quality assessment and improvement activities; conduct member outreach and education; resolve member and provider issues; and perform utilization management of services and provide care coordination for members receiving Medicaid-covered behavioral health services. Magellan of Virginia’s authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Providers under contract with Magellan of Virginia should consult Magellan’s National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424- 4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

All Residential Treatment Service providers are responsible for adhering to the residential treatment regulations defined in 12 VAC 30-50, 12VAC30-60, 12VAC30-130, this manual, their provider contract with the BHSA, and state and federal regulations.

Commonwealth Coordinated Care Plus (CCC Plus) Program (RTS)

CCC Plus is a managed long term services and supports (LTSS) program. This mandatory Medicaid managed care program will serve individuals with disabilities and complex care needs.

Target Population –

1. Individuals who receive Medicare benefits and full Medicaid benefits (dual eligible), including members enrolled in Commonwealth Coordinated Care (CCC). CCC members will transition as of January 1, 2018.
2. Individuals who receive Medicaid LTSS in a facility or through CCC Plus Waiver except Alzheimer's Assisted Living waiver. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence waivers, known as the Developmental Disabilities (DD) waivers, will enroll for their non-waiver services only. At this time, DD waiver services will continue to be covered through Medicaid fee-for- service.
3. Individuals who are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including ABD individuals currently enrolled in the Medallion 3.0 program. Medallion ABD members who are not enrolled in the CCC Plus Waiver (per 2 above) will transition as of January 1, 2018.

Medallion 3.0 (RTS)

Medallion 3.0 is a statewide mandatory managed care program for Medicaid and FAMIS members. The Medallion 3.0 MCOs serve primarily children, pregnant women and adults who are not enrolled in Medicare. The program is approved by the Centers for Medicare & Medicaid Services through a 1915(b) waiver.

Additional information about the Medallion 3.0 program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

For Medallion MCO members, assessment and evaluation, and outpatient psychiatric therapy services (individual, family, and group) are handled through the member's MCO. MCOs may have different service authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the member's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the member's MCO directly for information regarding the

contractual coverage, and reimbursement guidelines for services provided through the MCO. MCO contact information is available on the DMAS website at https://www.virginiamanagedcare.com.

Certain services, however, are carved out of Medallion 3.0 managed care and will continue to be obtained through fee-for-service (e.g., dental and community mental health rehabilitation services). A complete list of carved out services are located online at: http://www.dmas.virginia.gov/Content_atchs/mc/MCRG_Member_2015_04262016_v2.pdf.

Residential Treatment Coverage for Managed Care Enrollees (RTS)

The following Residential Treatment Services are carved-out of the CCC Plus and Medallion 3.0 MCO contracts and are covered for Medicaid enrollees through fee-for-service, in accordance with DMAS fee-for-service established coverage criteria and guidelines. Medicaid MCOs receive data on the Residential Treatment Services utilized by their members. Providers of Residential Treatment Services may be contacted by the MCOs to discuss the care of these individuals.

Please note that FAMIS and FAMIS MOMS enrollees covered by Medallion 3.0 Managed Care are not eligible for Residential Treatment Services including TGHs and PRTFs.

Medicaid MCO enrollees seeking Residential Treatment Services shall follow the assessment and certification process for individuals. The Independent Assessment, Certification and Coordination Team (IACCT) will complete the independent certification process as described in this chapter.

Managed Care Coverage, Eligibility and TGH Admissions

If a Medicaid enrollee in a MCO is eligible for and chooses TGH services, the individual will remain enrolled in their MCO after admission. If the individual transfers to a TGH after a PRTF stay, the eligible individual will be enrolled into a MCO. Professional services are covered by the MCOs thus the individual practitioners will need to be enrolled with the MCO. The TGH services are covered by Magellan of Virginia.

Managed Care Coverage, Eligibility and PRTF and EPSDT TGH Admissions

Medicaid members who are placed in an PRTF or EPSDT TGH setting are not eligible to participate in the Medicaid MCO programs. If the Medicaid enrollee is admitted to a PRTF or EPSDT TGH, they will be removed from the MCO effective on the day of admission to the PRTF or EPSDT TGH. The PRFT or EPSDT TGH services and most professional services will be covered by Magellan of Virginia. There are certain

laboratory services that will be covered by DMAS.

Qualified Medicare Beneficiaries (QMBs) - Coverage Limitations

Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the member's co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE CO-INSURANCE AND DEDUCTIBLE." The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

Providers under contract with the MMP should contact the MMP directly for more information.

Client Medical Management (CMM) Program

As described in Chapters I and VI, the Medicaid Program may designate certain members to be restricted to specific physicians and pharmacists. When this occurs, it is noted on the member's Medicaid card. A Medicaid-enrolled physician, who is not the designated primary provider, may provide and be paid for services to these members only,

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the member;
- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to physicians affiliated with the non-designated primary provider in delivering the necessary services; and
- For other services covered by DMAS, which are excluded from the CMM Program requirements.

Transportation (RTS)

TRANSPORTATION

Non-Emergency Medical Transportation (NEMT) is transportation of a Medicaid member to a non-emergency Medicaid-covered service. NEMT is not transportation where emergency services are required. Members should dial 9-1-1 if immediate response is needed for

emergencies or worsening conditions that threaten life or limb.

To arrange NEMT for FFS or MCO enrolled members please contact the contracted transportation broker to arrange for transportation. A transportation contacts list for both FFS and MCOs is available on the DMAS website at http://dmas.virginia.gov/#/nemtservices.

Medicaid covers non-emergency Medicaid transportation to residential treatment covered services and interventions including the provision of family engagement activities.

Non-emergency transportation to and from Medicaid-covered services, including psychiatric appointments, must be preauthorized by and billed to the Medicaid transportation broker for FFS members or the member's assigned MCO or MCO transportation contractor and is not included as part of the Residential Treatment Service. Individual providers and agencies, with the exception of state psychiatric hospitals, may seek mileage reimbursement through the transportation broker for transportation to and from Medicaid-covered services. Additional information is available on the DMAS website at http://www.dmas.virginia.gov/#/nemtservices.

To make transportation reservations or request mileage reimbursement preauthorization for the FFS NEMT program please call 1-866-386-8331 Reservations for transportation must be made five days in advance unless the trip is urgent in nature.

Telemedicine Services (RTS)

TELEMEDICINE SERVICES

DMAS reimburses for telemedicine services under limited circumstances. Telemedicine is the real-time or near real-time exchange of information for diagnosing and treating medical conditions. Telemedicine utilizes audio/video connections linking medical practitioners in one locality with medical practitioners in another locality. DMAS recognizes telemedicine as a means for delivering some covered Medicaid services. Please refer to the Virginia Medicaid Memo dated May 13, 2014: "Updates to Telemedicine Coverage". Medicaid Memos are posted at: https://www.virginiamedicaid.dmas.virginia.gov under Provider Services. For managed care enrolled members, the member's plan may cover additional telemedicine/telehealth services and have different requirements. Providers should direct specific telemedicine/telehealth coverage questions to the member's MCO.

Service Criteria and Requirements (RTS)

> Residential Treatment Services are behavioral health interventions in nature and are intended to provide clinical treatment to those individuals with significant mental illness or children with, or at risk of developing, serious emotional disturbances.

Residential Treatment Services as defined by this program manual consist of two levels of care: Psychiatric Residential Treatment Facility (PRTF) services and Therapeutic Group Home (TGH) services. Each level of care is defined as a distinct program with all applicable program rules grouped according to the level of care. The services available under the Early and Periodic Screening, Diagnosis and Treatment use the same level of care descriptions and are described under the EPSDT heading which describes the required activities that are distinct in each level of care setting.

The requirements for certification of need processes and the Independent Assessment, Certification and Coordination Teams (IACCT) are defined in this chapter as they apply to both levels of care.

Residential Treatment Services include benefits available to individuals who meet the service specific medical necessity criteria based on diagnoses made by Licensed Mental Health Professionals practicing within the scope of their licenses.

All services must be described with sufficient detail in a Plan of Care based on assessed needs of the individual defined in the assessment, the plan of care, most recent treatment team review and clinical review of the individual's treatment needs. These services are person-centered with emphasis on the delivery of youth guided and family driven principles. The individuals who are receiving these services shall be included in all service planning activities.

Level A Group Home Level of Care

Prior to revisions associated with Residential Treatment Services regulations established three levels of residential care, i.e., Level A Group Home, Level B Group Home, and Level C Psychiatric Residential Treatment Facility. Research of the licensing requirements of Department of Behavioral Health and Developmental Services (DBHDS), Department of Social Services (DSS) and Medicaid regulations indicates that DSS licensed Level A Group Homes will not be eligible for continued Medicaid reimbursement. Medicaid regulations require therapeutic group home programs to provide counseling services and therapeutic interventions. The therapeutic interventions are not an allowable service under the DSS licensure for Level A Group Homes.

Level A Group Home Transition Process (effective July 1, 2017)

Revised regulations establish two levels of residential care: PRTF and TGH. Both levels of care require licensure by DBHDS.

In order to better align service delivery with federal mandates and licensing requirements, Level A group home service providers who wish to provide continued

Medicaid covered services and be reimbursed by Medicaid must obtain a TGH license from DBHDS. As instructed in the DMAS Program Manual update issued on December 9, 2016, Level A service providers were to contact DBHDS and indicate their interest in applying for licensure by February 1, 2017. On January 20, 2017, DBHDS conducted an information session to Level A providers, outlining the transition process to become licensed as a TGH. As of February 1, 2017, Magellan of Virginia stopped enrolling new Level A providers with licenses issued by DSS.

As of May 1, 2018, DMAS and Magellan of Virginia will no longer reimburse for therapeutic group home services provided by a DSS licensed facility.

Level A Transition Summary:

Current Level A group home service providers who wish to transition and obtain a DBHDS TGH license must apply by June 30, 2017. The DBHDS application process can take up to one year to complete. Magellan of Virginia will continue to authorize and reimburse TGH care to Level A providers transitioning to TGH until May 1, 2018 if Level A providers have evidence of completing the following steps of the process:

1. submitted their notice of intent to DBHDS;
2. attended the DBHDS training on January 20, 2017;
3. provided Magellan of Virginia a copy of DSS license by February 1, 2017; and
4. submitted their application and policy and procedures to DBHDS by June 30, 2017.

To assist with a smooth transition, current Level A providers who have not completed the DBHDS application by June 30, 2017 will be able to enroll as a TGH, however their program participation status will be limited if the provider is not able to meet the TGH enrollment criteria. Providers who did not apply to DBHDS by June 30, 2017 will not be reimbursed for any new admissions with a certificate of need dated after September 30, 2017. For providers who did not apply for a license, reimbursement will be allowed only for initial and concurrent authorizations for anyone admitted on or prior to September 30, 2017.

Current providers of Community-Based Residential Services for Children and Adolescents under 21 (Level A) will no longer be eligible for continued Medicaid reimbursement as of May 1, 2018 For providers that applied to DBHDS after June 30, 2017 and have not obtained a Therapeutic Group Home license by April 30, 2018, Magellan of Virginia will terminate the Level A service provider agreement and contract

effective on May 1, 2018. By terminating the Level A provider contract, Magellan of Virginia will prevent future submissions and reimbursement for CPT code H2022, for those providers.

Level A providers who have applied to DBHDS for a TGH license by June 30, 2017 will be able to do the following:

- Continue to accept new Level A admissions via the IACCT process using TGH medical necessity criteria (MNC); and
- Continue receiving reimbursement for authorized services through April 30, 2018.

Level A providers who have not applied to DBHDS for a TGH license by June 30, 2017 will be able to do the following:

- Accept new Level A admissions via the IACCT process through September 30, 2017 using TGH medical necessity criteria;
- Receive reimbursement for previously authorized admissions through April 30, 2018; and
- May begin the DBHDS licensure process after June 30, 2017 but will not be able to receive reimbursement after April 30, 2018 until a DBHDS license is issued.

Based on data received from DBHDS related to application status, beginning March 1, 2018, Magellan of Virginia will identify those providers with open authorizations that extend beyond April 30, 2018. For providers who have not obtained a TGH license, Magellan of Virginia will provide care coordination for those members that remain in placement prior to May 1, 2018. Care coordination will include reaching out to the providers and the legal guardian of the member to provide notice and assist in identifying alternative placements for youth that continue to meet medical necessity criteria for TGH services. For members who do not continue to meet TGH medical necessity criteria, Magellan of Virginia can assist in linking member to community based services. Legal guardians may choose to seek alternative funding for the child to remain in the DSS facility. This process will begin in March 2018 in order to allow Magellan of Virginia and providers sixty (60) days to work collaboratively on appropriately transitioning these children by May 1, 2018.

Definitions (RTS)

DEFINITIONS

"Active treatment" means implementation of an initial plan of care (IPOC) and comprehensive individual plan of care (CIPOC) that shall be developed, supervised, and approved by the family or legally authorized representative, treating physician, psychiatrist, or LMHP responsible for the overall supervision of the CIPOC. Each plan of care shall be designed to improve the youth's condition and to achieve the youth's safe discharge from residential care at the earliest possible time.

"Activities of Daily Living (ADL) Restoration" means a face-to-face interaction provided on an individual or group basis to assist youth in the restoration of lost ADL skills that are necessary to achieve the goals established in the youth's plan of care. Services address performance deficits related to a lack of physical, cognitive or psychosocial skills which hinder the ability of the youth to complete ADLs. Services include (i) restoring acceptable habits, behaviors and attitudes related to daily health activities and personal care/hygiene and (ii) assisting the youth restoring and regaining functional ADL skills and appropriate behavior related to health and safety.

"Assessment" means the face-to-face interaction by an LMHP, LMHP-R, LMHP-RP or LMHP-S to obtain information from the youth and parent, guardian or other family member, as appropriate, utilizing a tool or series of tools to provide a comprehensive evaluation and review of the youth's mental health status. The assessment shall include a documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.

"Certificate of need" or "CON" means a written statement by an independent certification team that services in a TGH or PRTF are or were needed.

"Comprehensive Individual Plan of Care" or "CIPOC" means a person-centered plan of care that meets all of the requirements of this subsection, is specific to the youth's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

"Crisis" means a deteriorating or unstable situation, often developing suddenly that produces an acute, heightened emotional, mental, physical, medical, or behavioral event.

"Crisis management" means immediately provided activities and interventions designed to rapidly manage a crisis. The activities and interventions include behavioral health care to provide immediate assistance to youth experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity. Activities shall include assessment and short term counseling designed to stabilize the youth.

"Daily supervision" means the supervision provided in a PRTF through a resident-to-staff ratio as approved by the Department of Behavioral health and Developmental Services (DBHDS) Office of Licensure, with documented supervision checks every 15 minutes throughout the 24-hour period.

"Discharge planning" means family and locality-based care coordination that begins upon admission to a PRTF or TGH with the goal of transitioning the youth out of the PRTF or TGH to a less restrictive care setting with continued, clinically-appropriate services as soon as possible upon discharge. Discharge plans shall be recommended by the treating physician, psychiatrist, or treating LMHP responsible for the overall supervision of CIPOC and shall be approved by the BHSA.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

"Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" **EPSDT** is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of youth's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible,

before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the member. Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a youth through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by the DMAS or its agent as medically necessary.

"Family engagement" means a family-centered and strengths-based approach to partnering with families in making decisions, setting goals, achieving desired outcomes, and promoting safety, permanency, and well-being for youth and families. Family engagement requires ongoing opportunities for a youth to build and maintain meaningful relationships with family members, e.g. frequent, unscheduled, and non-contingent phone calls and visits between a youth and family members. Family engagement may also include enhancing or facilitating the development of the youth's relationship with other family members and supportive adults responsible for the youth's care and well-being upon discharge.

"Family engagement activity" means an intervention, which may be provided either in person or on the phone, consisting of family psychoeducational training or coaching; transition planning with the family; family and independent living skills; and training on accessing community supports as identified in the IPOC and CIPOC. Family engagement activity does not include and is not the same as family therapy.

"Family therapy" means counseling services involving the youth's family and significant others to advance the treatment goals, when (1) the counseling with the family member and significant others is for the direct benefit of the youth, (2) the counseling is not aimed at addressing treatment needs of the youth's family or significant others, and (3) the youth is present except when it is clinically appropriate for the youth to be absent in order to advance the youth's treatment goals. Family therapy shall be aligned with the goals of the youth's treatment plan. All family therapy services furnished are for the direct benefit of the youth, in accordance with the youth's needs and treatment goals identified in the youth's treatment plan, and for the purpose of assisting in the youth's recovery.

"IACCT" or "Independent Assessment, Certification, and Coordination Team" means a team that consists of various professionals who will collaborate to provide assessments or assist in gathering medical and behavioral health treatment records that will be used to fully assess the youth and family needs in order to formulate a preliminary plan of care. The IACCT is essential in ensuring the most clinically appropriate, least restrictive setting, and that care is provided in a manner that best suits the needs of each youth and family including preferences related to provider location, specialties, spoken languages, gender, and cultural aspects. The IACCT will also ensure family engagement in the decision making process and throughout the course of treatment.

"Independent certification team" means a team that has competence in diagnosis and treatment of mental illness, preferably in child and adolescent psychiatry, and has knowledge of the youth's situation, and is composed of at least one physician and one LMHP, LMHP-R, LMHP-RP or LMHP-S. The independent certification team shall be a DMAS-authorized contractor with contractual or employment relationships with the required team members. Effective July 1, 2017 certification teams will be called the Independent Assessment, Certification and Coordination Team (IACCT).

"Initial plan of care" or "IPOC" means a person-centered plan of care established at admission that meets all of the requirements of this manual, is specific to the youth's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

"Institution for Mental Disease (IMD)" means a hospital, nursing facility, or other institution with more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

"Intervention" means scheduled therapeutic treatment included in the IPOC and CIPOC to help the youth achieve his or her plan of care goals and objectives. Interventions include, but are not limited to: skills restoration; ADL restoration; individual, group, and family therapy; individual or group psychoeducation; structured behavior support and training activities; recreation, art, and music therapies; community integration activities that promote or assist in the youth's ability to acquire coping and functional or self-regulating behavior skills; therapeutic passes and family engagement activities. Interventions shall not include medical or dental appointments, physician services,

medication evaluation or management provided by a licensed clinician or physician, and shall not include school attendance. Interventions shall be provided in the TGH or PRTF and, when clinically necessary, in a community setting, or as part of a therapeutic pass activity. All interventions and settings of the intervention shall be established in the IPOC and CIPOC.

“LDSS” means Local Department of Social Services

"Licensed Assistant Behavior Analyst" or “LABA” means an individual who has met the licensing requirements for an assistant behavior analyst as defined in 18VAC85-150-10 et seq. and holds a valid license issued by the Virginia Board of Medicine.

"Licensed behavior analyst" or “LBA” means a LMHP who has met the licensing requirements for a behavior analyst as defined in 18VAC85-150-10 et seq. and holds a valid license issued by the Virginia Board of Medicine.

“Licensed Mental Health Professional” or “LMHP” means the same as defined in 12VAC35-105-20.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. "LMHP-supervisee in social work," "LMHP-supervisee" or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work.

"Physician" means an individual licensed to practice medicine or osteopathic medicine in Virginia, as defined in Va. Code §54.1-2900.

“Non-psychotherapy interventions” means those interventions other than individual, group or family therapy.

"Psychiatric residential treatment facility (PRTF)," means the same as defined in 42 CFR 483.352, and is a 24-hour, supervised, clinically and medically-necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of a youth in order to prevent or minimize the need for more intensive inpatient treatment.

“Psychotherapy” or “therapy” means the use of psychological methods in a professional relationships to assist a person or persons to acquire great human effectiveness or to modify feelings, conditions, attitudes, and behaviors that are emotionally, intellectually, or socially ineffectual or maladaptive. Psychotherapy may only be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S.

"Recertification" means a certification other than the initial certification of need for each applicant or recipient for whom PRTF or TGH services are needed.

"Room and board" means a component of the total daily cost for placement in a licensed PRTF. Residential room and board costs are maintenance costs associated with placement in a licensed PRTF, and include a semi-private room,

three meals and two snacks per day, and personal care items. Room and board costs are reimbursed only for PRTF settings.

“Skills Restoration” means a face-to-face service to assist youth in the restoration of lost skills that are necessary to achieve the goals established in the youth’s plan of care. Services include assisting the youth in restoring self-management, interpersonal, communication and problem solving skills through modeling, coaching and cueing.

"Therapeutic group home (TGH)" means a congregate residential service providing 24-hour supervision in a community-based home having eight or fewer residents. TGH providers must meet all requirements in DBHDS Regulations for Children’s Residential Facilities (12VAC 35-46).

"Therapeutic pass” means time at home or time with family consisting of partial or entire days away from the TGH or PRTF as clinically indicated in the plan of care and as paired with facility-based and community-based interventions to promote discharge planning, community integration, and family engagement activities. Therapeutic passes are not solely recreational but are a therapeutic component of the plan of care and are designed for the direct benefit of the youth.

“Therapeutic services” means the structured therapeutic program designed to restore appropriate skills necessary to promote prosocial behavior and healthy living to include: the restoration of coping skills; family living and health awareness; interpersonal skills; communication skills; and, stress management skills. Therapeutic services also engage families and reflect family-driven practices that correlate to sustained positive outcomes post-discharge for youth and their family members. Therapeutic services include but are not limited to assessment, individualized treatment planning and interventions.

“Treatment planning” means development, implementing, monitoring and updating the person-centered IPOC and CIPOC, that is specific to the youth’s unique treatment needs and acuity levels.

"Youth" means the individual under 21 years of age.

Residential Treatment Services (RTS)

RESIDENTIAL TREATMENT SERVICES

Residential Treatment Services as defined by this program manual consist of two levels of care: PRTF services and TGH services. Each level of care is defined as a distinct program with all applicable program rules grouped according to the level of care.

Residential Treatment Services include benefits available to youth who meet the service specific medical necessity criteria based on diagnoses made by LMHPs, LMHP-Rs, LMHP-RPs and LMHP-Ss acting within their scope of practice.

All services must be described with sufficient detail in an IPOC or CIPOC based on assessed needs of the youth defined in the assessment, the plan of care, most recent treatment team review and clinical review of the youth’s treatment needs and are subject to approval for Medicaid reimbursement. These services are person-centered with emphasis on the delivery of youth guided and family driven principles. The youth who are receiving these services shall be included in all service planning activities.

Noted below are two (2) concepts that should be reflected in all providers' service delivery practices.

Recovery and Resiliency

DMAS encourages providers to integrate individualized, recovery based behavioral health services into their practices and service delivery operations. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Cultural and Linguistic Competency

DMAS encourages providers to demonstrate an understanding and respect for each individual's health-related beliefs and cultural values through the establishment of policies, practices and allocation of resources that support culturally and linguistically appropriate services. Culture has a significant impact on how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express, mental and emotional distress, illness and conditions.

Development of cultural and linguistic competency means that providers have the ability to value diversity, adapt to diverse populations, obtain any needed education and training in order to enhance cultural knowledge, work within values and beliefs that may be different from their own, and be capable of evolving over time as cultures change.

Providers licensed by the DBHDS should refer to DBHDS for guidance in this area.

PRTF and TGH Program Requirement Changes

The 2017 revision to the regulations governing residential treatment services establish practices promoting the creation of strong and closely coordinated partnerships and collaborations between families, youth, and community/residential based treatment service providers. These partnerships help to ensure that comprehensive services and supports are family-driven, youth-guided, strengths-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes. The goal is to promote medically appropriate services, shorter lengths of stay, and reunification with the family unit to include support systems to maintain the youth successfully in the community.

Highlights of the program requirement changes included:

- Integrate Building Bridges Initiatives Core Values into program policy. Information on Building Bridges Initiatives is available on the Magellan of Virginia website at https://www.magellanofvirginia.com/for-providers/residential-program-process/;

- Establish treatment planning that is family driven and youth guided;
- Establish daily rather than weekly minimum interventions;
- Establish family engagement activities as allowable interventions, and establish minimum requirement for family engagement activity;
- Require ongoing opportunities for youth to build and maintain meaningful relationships with family members to include frequent, unscheduled, and non-contingent phone calls and visits between youth and family members;
- Allow "time at home" consisting of therapeutic passes home and family engagement activities and more types of residential service structures as allowed interventions;
- Allow exceptions to daily intervention requirements to support activities to transition back to the community;
- Require provider's discharge plan to be approved by Magellan of Virginia; and
- Establish new program coverage and medical necessity criteria for EPSDT Residential Treatment Services to be administered by Magellan of Virginia.

Family Finding Coordination with LDSS

For all youth placed in foster care, LDSS staff will initiate and administer a Relative Search/Parent Locator service to identify family and other connections that may be viable for youth upon admission to a TGH or PRTF. LDSS workers are responsible to assume the lead role in family finding activities including finding alternate family members to participate in family engagement. The facility's collaboration with the LDSS will serve to promote the location of additional family members by the LDSS in order to facilitate family finding and family engagement.

The facility will coordinate efforts with Magellan of Virginia and the youth's MCO as applicable to achieve effective family engagement strategies. Magellan of Virginia residential care managers will coordinate strategies and care management at least every 30 calendar days.

Residential Treatment Services Per Diem

Please refer to Chapter 5 for information on services included in the PRTF and TGH per diem and those services that can be reimbursed in addition to the per diem.

Services Provided Under Arrangement and Medically Necessary EPSDT Services

States must make available any services coverable under the EPSDT benefit and under 1905(a) of the Act for youth residing in a PRTF and who are determined to need the service in order to correct or ameliorate health conditions, regardless of whether such services are identified in the youth's plan of care. These EPSDT services may be provided by the PRTF, under arrangement with a qualified non-facility provider, and/or by a qualified provider in the community not affiliated with or under arrangement with the facility. Please see Chapter 5 for additional information.

Medically necessary EPSDT services are not required to be included in the youth's IPOC or CIPOC prior to initiation, however, all services provided to the youth shall be included in the CIPOC no later than the next 30 day plan of care review.

Service Authorization

All TGH and PRTF services, including EPSDT TGH and EPSDT PRTF services, require an IACCT recommendation and service authorization. Refer to the IACCT Appendix and Appendix C for details.

Magellan of Virginia Care Management (RTS)

Care Management is provided by Magellan of Virginia employed clinical staff who are licensed behavioral health clinicians. Care Management includes provider service coordination and coordination with CSA Coordinators/CSA Case Managers, LDSS Social Workers, CSB and Treatment Foster Care Case Managers. The central purpose of Care Management is to help individuals receive quality services in the most cost-effective manner. The primary activities of Care Management include utilization management, triage and referral, opening communication between identified providers, aligning care plans, discharge planning following 24 hours levels of care, continuity of care, care transition, quality management, and independent review.

DMAS and Magellan of Virginia agree that care coordination has two (2) main goals:

1. To improve the health and wellness of individuals with complex and special needs; and
2. To integrate services around the needs of the individual at the local level by working to make sure members receive appropriate services and experience desirable treatment outcomes.

Examples when Magellan of Virginia may provide care management to assist individuals and families include:

- Ambulatory follow-up and discharge planning (including follow-up appointments) for all individuals in inpatient and/or residential settings under their management;
- An MCO liaison at Magellan of Virginia will work with MCOs to develop strategies for identification of individuals with co-morbid behavioral health and medical needs and facilitate referrals into respective systems of care;
- Care coordination with Primary Care Physicians (PCPs); and
- Assistance with transferring cases from one provider to another.

Care Coordination

"Care coordination" in the regulations defined in 12VAC30-50-130 means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

The purpose of care coordination is to ensure that the individual receives all needed services and supports in the most effective and efficient manner, to provide informed and congruent treatment planning, to ensure open communication among all treating providers, and to ensure that these resources are well-coordinated and integrated.

According to the National Technical Assistance Center for Children's Mental Health, "intensive family involvement, meaningful discharge planning, and deliberate strategies to reintegrate back into the community are the essential components to the assurance of effective psychiatric treatment for youth. National research provides evidence that care coordination including these components improves child and family outcomes and results in positive return on investment." Through the focus groups and workgroups described above, DMAS received universal feedback that effective care coordination of services for youth with severe behavioral health needs is lacking across the Commonwealth.

To ensure that youth at risk of or receiving residential treatment services receive the benefits of effective care coordination, Magellan of Virginia will provide residential care coordination through Intensive Care Managers and Family Support Workers. These individuals will ensure the engagement of families, youth, and community- and residential-based treatment service providers in the comprehensive assessment of youth and family needs, determination of the most appropriate and least restrictive level of care, service planning, service delivery, and post- discharge follow-up. Emphasis on family-driven and youth-guided care will be a key hallmark of Magellan of Virginia's residential care coordination.

Service Provider Care Coordination is done in the spirit of collaboration with the treatment team and is meant to support the member on his or her path of recovery**.**

Service Provider Care Coordination includes:

- Assisting the individual to access and appropriately utilize needed services and supports;
- Assisting them to overcome barriers to being able to maximize the use of these resources;
- Actively collaborating with all internal and external service providers;
- Coordinating the services and supports provided by these individuals (including family members and significant others involved in the consumer's life);
- Assessing the effectiveness of these services/supports;

- Preventing duplication of services or the provision of unnecessary interventions and supports; and
- Revising the service plan as clinically indicated to ensure that service planning is consistent with other services being provided to the individual.

Care coordination between different providers is required and must be documented in the IPOC, CIPOC and Progress Notes. Care coordination serves to help align services to prevent duplication and is intended to complement the service planning and delivery efforts of each service. Providers must collaborate and share information among other health care providers and individuals who routinely come in contact with the individual, i.e. PCPs, case managers, probation officers, teachers, etc. and who are involved with the individual's health care and overall wellbeing in order to improve care.

Residential Services for Substance Use and Behavioral Health (RTS)

Effective April 1, 2017, DMAS implemented the Addiction and Recovery Treatment Services (ARTS) program for all members. For more information on the services, criteria, and staffing requirements, refer to the ARTS Provider Manual.

Addiction and Recovery Treatment Services (ARTS) Residential Treatment Services

ARTS residential services for adolescents include: American Society of Addiction Medicine (ASAM) Levels of Care. The ASAM levels of residential services vary in intensity from low, medium, to high. If the adolescent's primary diagnosis is a substance use disorder, please submit an ARTS residential service request to the MCO for managed care enrolled members or Magellan of Virginia for fee-for-service enrolled members. For assistance or a list of ARTS residential providers, contact the adolescent's MCO or Magellan of Virginia. Providers can also be contacted directly for services.

Behavioral Health Residential Treatment Services

Behavioral health residential services include: Therapeutic Group Home (TGH) and Psychiatric Residential Treatment Facility (PRTF) Each child seeking admission to behavioral health residential services (TGH or PRTF) will first receive the support of the local Independent Assessment, Certification and Coordination Team (IACCT) to assess the child's needs. If the youth's primary diagnosis is a mental health diagnosis, please submit a Residential Inquiry form to Magellan of Virginia to begin the process. This form can be found on the Magellan of Virginia website in the Residential Program Process section. For additional information on the IACCT process, please refer to IACCT overview guides on the Magellan of Virginia website in the Residential Program Process

section.

Interaction between ARTS and IACCT

If the youth is in a PRTF or TGH and it is determined that ARTS Residential services are needed, please notify the Magellan of Virginia Residential Care Manager (RCM) who will assist with identifying appropriate ARTS resources for the youth.

If the youth is in an ARTS Residential facility and needs to transition to a PRTF or a TGH, please submit an IACCT Inquiry form as soon as the need is identified.

Co-Occurring Disorders

A co-occurring disorder is the presence of substance use and mental health disorders occurring simultaneously without implication as to the causal effect of one over the other, nor which disorder is primary versus secondary. Individuals who are experiencing a co-occurring substance use and mental health disorder may experience greater impairments in functioning. Thus providers who are trained and practicing within the scope of their practice, in working with individuals with both substance use and mental health disorders should ensure both conditions are addressed in treatment. If a provider is not trained or licensed by DBHDS in the treatment of both substance use and mental health disorders, they should refer the member to an appropriate service provider.

For persons with co-occurring psychiatric and substance abuse conditions, providers are expected to integrate the treatment needs. There may be concurrent authorizations for psychiatric services and substance abuse services if medical necessity criteria are met for the requested service. Collaboration and coordination of care among all treating practitioners shall be documented. Providers should obtain a release of information from the member so they can collaborate to coordinate effective treatment

Independent Certification Process (RTS)

Medical Necessity Review Process Changes

Beginning on July 1, 2017 PRTF and TGH services will begin using different medical necessity criteria. Changes in the service authorization process was implemented on July 1, 2017 when Magellan of Virginia will stop using the current medical necessity criteria for Level A and Level B Group Home Services and will instead make authorization decisions in the new TGH Services using new medical necessity criteria and IACCT review process.

Both initial and concurrent authorizations will be issued using a maximum duration of

30 days based on medical necessity requirements and to allow for complex care coordination in order to transition to an appropriate level of care. Initial EPSDT cases will be authorized for a maximum duration of 60 calendar days based on medical necessity requirements. Concurrent EPSDT cases will be authorized for a maximum duration of 90 days based on medical necessity requirements.

The IACCT team will gather relevant information from which Magellan of Virginia will use to render a medical necessity determination.

The service review process used by Magellan of Virginia will assess the plan of care and treatment plan to determine if the services are adequate to treat the individual's needs in the residential or group home setting. The Magellan review will focus more intensively on the quality of care for the member while in the residential service setting.

Independent Assessment, Certification and Coordination Teams (IACCT)

CMS requires, per §441.153, that an independent certification team assess the needs of a youth to determine the appropriate level of care and, if appropriate, to certify medical necessity for residential treatment services. Membership and qualifications of the team are also stipulated in

§441.153. Historically, DMAS has not required the certification teams to be enrolled providers and did not reimburse the certification teams for their services. Effective January 1, 2017 DMAS will require that all certification teams are credentialed and contracted with Magellan of Virginia in order to administer the independent certification process on behalf of DMAS. DMAS will also allow localities to enter into a partnership agreement with DMAS to administer the IACCT process in collaboration with Magellan of Virginia. The new certification teams will be called the Independent Assessment, Certification and Coordination Team (IACCT) and the team will enhance the current certification process by:

- Ensuring care coordination and higher probability for improved outcomes;
- Following strict turnaround timeframes for assessing the need for treatment and level of care requirements;
- Accessing the established Medicaid grievance process as mandated by CMS;
- Ensuring freedom of choice in service providers as mandated by CMS; and
- Implementing Medical Necessity Criteria for all members who request residential care.

All Medicaid-eligible youth must be referred to Magellan of Virginia who will make

referral to the IACCT team for PRTF and TGH services. In addition, all inpatient providers and residential treatment providers must refer to Magellan of Virginia to initiate the IACCT certification process to assess and certify an appropriate level of care prior to being transferred to PRTF or TGH care from an inpatient setting. All IACCT decisions are due within 10 business days of the referral to Magellan of Virginia. A licensed mental health professional (LMHP) who is part of the IACCT will conduct a diagnostic assessment through a face-to-face meeting and the IACCT will determine the appropriate level of care. The IACCT is essential in ensuring the most clinically appropriate, least restrictive setting, and that care is provided in a manner that best suits the needs of each youth and family. The IACCT will also ensure family engagement in the decision making process and throughout the course of treatment.

IACCT Oversight and Support

Magellan of Virginia, as the DMAS Behavioral Health Administrator, will provide oversight to the IACCT process and facilitate implementation of best practices.

Magellan of Virginia will support the IACCT process through activities including:

- Ensure that all appropriate community services are explored in lieu of residential placement;
- Make the final medical necessity determination for residential placement;
- Handle all grievances and appeals per the established DMAS appeals process; and
- Provide freedom of choice of providers to youth and families.

Magellan of Virginia's Role

The Magellan of Virginia certification and care coordination model, i.e., IACCT, will utilize a single team for the assessment of care needs and care coordination. Magellan of Virginia will support the IACCT through Magellan of Virginia employed positions including Intensive Care Managers (ICM) and Family Support Coordinators (FSC).

The roles of these positions are described below:

Magellan of Virginia Residential Care Manager (RCM)

The RCM will notify the IACCT serving a locality of any youth from that locality referred to Magellan of Virginia for consideration of residential treatment.

In all circumstances, the RCM will:

a. Support the IACCT process by facilitating the collection of required assessments and behavioral and physical health histories;

b. Review the results from the assessments and recommendations of the IACCT and apply the established medical necessity criteria to determine Medicaid funding authorization; and
c. If residential treatment is initiated, the RCM will provide continued oversight around:
    - Treatment plan of care development,
    - Progress toward treatment goals including cans outcomes, and
    - Transition planning for return to the community. The RCM will remain involved with the IACCT following discharge as a coordination resource to ensure the outlined community plan with any necessary service authorizations is in place.

Magellan of Virginia Family Support Coordinator (FSC)

The FSC will perform outreach to the family or guardian to coordinate any face-to-face assessments, encourage and facilitate family engagement in any treatment option decisions, provide education for informed decision making regarding treatment, and offer any other support or assistance to the family throughout the course of treatment. The FSC's primary role is to provide support to the family, helping them to stay involved while their child is in care and preparing for a successful reunification upon the youth's discharge.

IACCT Staffing Requirements

- Each IACCT team[1] will include at a minimum:

    - A Licensed Mental Health Professional (LMHP) or an approved LMHP Resident or Supervisee (LMHP-resident; LMHP-resident in psychology; or LMHP- supervisee in social work) who performs the required diagnostic assessment, i.e., psychosocial history. The LMHP OR LMHP Resident/Supervisee will collect, review, and/or complete the Child and Adolescent Needs and Strengths Tool (CANS) and Adverse Childhood Experiences (ACEs) screening tool (note, only the Whole Child Assessment-ACEs only or the Center for Youth Wellness ACEs Questionnaire are allowed to be utilized for this required screening).
    - A physician, who either 1) actively sees this member for medical care2) can be accessed through the youth's MCO or 3) is identified by the locality as physician willing to engage in this process with identified youth. Physicians engaged in this process need to have knowledge of the service delivery system and are able to assess the youth's medical history and current status through either a face to face contact scheduled during the IACCT

process or via their current health related knowledge of this youth including having seen the youth face to face in the last 13 months; and
- The youth and family/legally authorized representative who are active participants in the assessment and decision-making process.

It is expected that the team will also include representatives of local agencies and other supports involved in the child's plan of care who will provide information to the team regarding the youth's service history and current level of functioning.

IACCT Required Activities

- Receive and respond to Residential Inquiry requests and IACCT Referrals from Magellan of Virginia of youth[2] to be considered for residential treatment services;
- Determine each youth's appropriate level of care and certify, as appropriate, the need for residential treatment services. Assessment must include psychosocial history, CANS, approved ACEs tool (Center for Youth Wellness-Adverse Childhood Experiences Questionnaire as completed by an MD, PA, of CNP or the Whole Child Assessment – Adverse Childhood Experiences- Only completed by a LMHP or LMHP Supervisee/Resident), medical history and current status; and
- If the youth has had a CANS (including the Magellan of Virginia 2016 CANS or the Virginia Comprehensive CANS) completed within the last 30 days, the LMHP/LMHP Supervisee/Resident can utilize this CANS for the assessment.

For **contracted IACCT providers** completing the VA CANS Comprehensive, the contracted IACCT provider LMHP or LMHP Resident/Supervisee must transfer the ratings to the Magellan of Virginia CANS 2016 system to submit the CANS 2016 Youth Report with the IACCT SRA.

For **identified IACCT locality partners (MOU with DMAS)**, the LMHP or LMHP Resident/Supervisee will submit the VA CANS Youth Report from CANVaS with the IACCT SRA.

- Adhere to IACCT procedures established by DMAS regulations, provider manuals, and Magellan of Virginia contractual agreements including:

  - Meet all specified timeframes;
  - Assess the youth and family's needs;
  - Apply medical necessity criteria in accordance with DMAS regulations;
  - Ensure the youth is served in the least restrictive environment in

accordance with the Department of Justice Settlement Agreement; and
    - Ensure family engagement throughout the assessment process.

- Assume responsibility for assessment of youth in inpatient facilities who are referred for consideration of transfer to a residential treatment facility.[3]

    - The LMHP OR LMHP Resident/Supervisee will assess the youth (expedited, if possible) through either a face-to-face or telemedicine contact. For youth who are currently in an inpatient setting where telemedicine is not available and distance is a barrier for the IACCT LMHP or LMHP Resident/Supervisee, a telephonic interview with the youth may be conducted while the IACCT LMHP or LMHP Resident/Supervisee conducts a face to face with the legal guardian.
    - The LMHP OR LMHP Resident/Supervisee will coordinate with the inpatient facility to gather diagnostic and clinical assessments completed during the youth's inpatient treatment.
    - The LMHP OR LMHP Resident/Supervisee will partner with the inpatient facility to complete the CON with the facility physician[4] and to make sure all viable options, including community based options, have been explored.
- Participate in care coordination with Magellan of Virginia, the family, the youth's primary physician, the local CSB, the local DSS (as appropriate), the youth's school, and community-based service providers serving the youth and family.
- Ensure family engagement throughout the course of treatment.

[1] Team members may participate in person or by teleconference

[2] Each IACCT will receive referrals for a contracted catchment area. All youth shall be referred to the IACCT serving the city/county of the youth's legal residence.

[3] As an alternative, the responsible IACCT may opt to coordinate with an IACCT in close geographic proximity to the facility to conduct the assessment.

[4] The facility physician cannot be referring to an affiliated residential program. If this is a conflict, Magellan of Virginia will assist in engaging the MCO physician.

IACCT Timeframes (RTS)

1. When a residential inquiry is received by Magellan of Virginia, a Magellan of Virginia Residential Care Manager (RCM) will conduct the education session[5] to

the youth and the parent/legally authorized representative.

2. After all education sessions, the parent(s)/legally authorized representatives' wishes for community based services or for engaging in the IACCT process shall be documented. The parent(s)/legally authorized representatives' verbal response for community based services or engaging in the IACCT process shall be documented. Magellan of Virginia will initiate a referral to the identified locality partner or the contracted IACCT provider to begin the IACCT process.

3. The IACCT shall assess the treatment needs of the individual and recommend a level of care ***within 10 business days from the referral*** from Magellan of Virginia.

    a. The LMHP or LMHP Resident/Supervisee will conduct the face to face assessment within two business days of the referral from Magellan of Virginia.

    b. If the youth and parent/legally authorized representative are unable to attend the face to face appointment ***within two business days***, the LMHP OR LMHP Resident/Supervisee must notify the Magellan of Virginia Residential Care Manager (RCM) of this missed appointment and request a ***3 business day extension***.

    c. ***Up to two 3 day extensions*** can be offered due to the youth and parent/legally authorized representative being unable to attend a scheduled appointment.

    d. ***Up to two 3 day extensions*** can be offered for challenges engaging a physician in completing a review of a known client or face to face meeting with an unknown client and making Certificate of Need (CON) recommendations.

    NOTE: No more than a total of two 3 business day extensions can be given during the IACCT process which allows for a possible 16 business day timeline.

4. If the child has been referred to community based service options via the IACCT process, the IACCT in collaboration with the youth's legal guardian will develop a community based plan of care.

    - For **contracted IACCT providers**, the Magellan of Virginia RCM will assist with a referral list for community providers and the RCM and FSC are available to the youth and legal guardian for up to 90 days after the IACCT process is completed so that they can provide ongoing support and care coordination.
    - For **identified IACCT locality partners (MOU with DMAS)**, the Magellan of Virginia RCM will assist with a referral list for community providers. The locality partner will be responsible for providing ongoing support and care coordination for the youth and legal guardian.

    NOTE: In all cases, when the youth's legal guardian is the LDSS all coordination will occur with the identified LDSS foster care worker as required by the court.

    If a residential treatment level of care has been determined, then the following steps will occur:

    a. The CON shall be effective for ***thirty calendar days*** prior to admission.

    b. The IACCT shall provide the completed CON to Magellan of Virginia ***within one calendar day*** of completing the CON.

    c. The IACCT shall provide the completed CON to the facility ***within one calendar day*** of the facility being identified. Note, if the youth is in an inpatient or residential treatment facility during the IACCT process AND the IACCT process results in determining the youth meets DMAS medical necessity requirements for residential treatment services, the facilities' current CON may be utilized or a facility-based physician engaged in the youth's treatment can complete Magellan of Virginia's Retroactive CON.

5. If the youth has been authorized for residential treatment service options via the

IACCT process and medical necessity determination, the RCM will provide a listing of credentialed residential facilities to the youth's legal guardian so that the legal guardian and youth can begin to make their selection of facility based care. The RCM will continue to engage in care coordination at a minimum of every 30 days.

The RCM and FSC are available to the youth and family throughout the youth's placement in a residential treatment facility.

When the youth is discharged from a residential facility, the RCM and FSC are available to the youth and (foster care worker) for up to 90 days after discharge from a residential facility to provide ongoing support and care coordination.

6. If the child receives residential treatment services, the IACCT LMHP or LHMP Resident/Supervisee will conduct a reassessment at 90-days or earlier as deemed clinically appropriate. The 90-day reassessment will include a CANS and a psychosocial addendum when there has been a significant life change for the youth or family. The reassessment process with include a review of CANS outcomes as it relates to treatment recommendations via the completion of the Magellan of Virginia Re-Assessment Clinical CANS grid.

    - For **contracted IACCT providers,** the Magellan of Virginia System will produce individualized CANS outcome reports that the LMHP or LMHP Supervisee/Resident can utilize to complete the Magellan of Virginia Re-Assessment Clinical CANS grid.
    - For **identified IACCT locality partners (MOU with DMAS)**, all CANs will be submitted via attachment and therefore the Magellan of Virginia System cannot produce individualized CANS outcome reports. The LMHP or LMHP Supervisee/Resident will need to compare the initial and 90 day CANS items submission to complete the required Magellan of Virginia Re-Assessment Clinical CANS grid.

For youth with a Certificate of Need (CON) completed prior to July 1 2017, Magellan will require the following from the PRTF or TGH provider when submitting a continued stay request:

- Youth connected with Children's Services Act (CSA):

i. Service Authorization Request form (Continued Stay), Comprehensive Individual Plan of Care (CIPOC), Rate Sheet, Child and Adolescent Needs and Strengths Assessment (CANS); and
ii. Attach the CANS to the Facility Service Authorization Request Form versus inputting into Managed Outcomes for the IACCT process at www.MagellanProvider.com.

- Youth not connected with CSA:

i. Service Authorization Request form (Continued Stay), CIPOC; and

ii. Continued stay criteria for these members with a CON completed prior to July 1, 2017 shall be met as defined in the Criteria for Continued Stay sections for PRTF and TGH in Chapter 4 of the Residential Treatment Services Manual.

[5] Education Session will ensure that the parent(s)/legally authorized representative(s) is aware of community resources and understands the IACCT process so that they can consider the least restrictive mental health services available that best meet the needs of their child.

IACCT Processes (RTS)

Members Eligible for Medicaid at the Time of Admission

For individuals who are already eligible for Medicaid at the time of admission, the independent certification team shall be a DMAS-authorized contractor with competence in the diagnosis and treatment of mental illness, preferably in child psychiatry, and have knowledge of the individual's situation and service availability in the individual's local service area. The team shall be composed of at least one physician and one LMHP. An individual's parent or legally authorized representative shall be included in the certification process.

Emergency Placements for Foster Care Youth

DMAS and the LDSS have completed final edits on the Residential Treatment

Regulations to defer to DSS for guidance on defining emergency placements for foster care youth. The emergency placements for both Medicaid eligible and non-Medicaid eligible foster care youth will be allowed to be admitted to a PRTF or a TGH immediately according to DSS protocol that will ensure all potential community placement options are not viable prior to placing a child into services. The IACCT will receive notice of all emergency placements from the PRTF or the TGH within five days of admission to care or five days from the date that Medicaid eligibility and coverage begins. For emergency admissions, the certification must be made by the team responsible for the comprehensive individual plan of care (CIPOC) within 14 calendar days after admission. These certifications of need for these “emergency admissions” shall be made by the team responsible for the CIPOC and the certification shall cover any period of time after admission and before for which claims are made for reimbursement by Medicaid. After processing an emergency admission, the PRTF or TGH shall notify Magellan of Virginia of the individual's status as being under the care of the facility within 5 days.

The Facility will not receive DMAS reimbursement approval until the certification of need is received by Magellan of Virginia and assessed by the children’s residential services care management staff. All reimbursement approvals will cover the dates of admission and afterward if the individual is Medicaid eligible at the time of admission and is referred to the IACCT within 5 days of admission or within 5 days of being determined eligible for Medicaid.

Individuals Not Medicaid Eligible at Admission to Residential Treatment Services

For individuals who apply and become eligible for Medicaid while admitted to PRTF or TGH, the certification shall be made by the team responsible for the CIPOC and certification of need (CON), within 14 calendar days from admission. The certification shall cover any period of time before the application for Medicaid eligibility for which claims are made for reimbursement by Medicaid. The facility will not receive DMAS reimbursement approval until the certification of need is received by Magellan of Virginia and assessed by the children’s residential services care management staff. All reimbursement approvals will cover the dates of admission and afterward if the individual is Medicaid eligible at the time of admission and is referred to the IACCT within 5 calendar days of admission or within 5 calendar days of being determined eligible for Medicaid.

All individuals entering a PRTF or TGH utilizing private medical insurance who will become eligible for enrollment in Medicaid within 30 days following the facility admission are required to have an independent certification of need completed by the team responsible for the plan of care at the facility will provide the certificate of need using the facilities treatment team within 14 calendar days from admission. The team providing the certificate of need must include the following professionals:

- In IACCT Special Considerations, the CON is completed by the team responsible for the plan of care in emergency and retroactive placements.

The team responsible for the plan of care shall include in TGH, as a minimum must include:

1. A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist; and
2. The team shall also include one of the following: LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP. Upon the individual's enrollment into the Medicaid program, the residential treatment facility or IMD shall notify Magellan of Virginia of the individual's status as being under the care of the facility within five calendar days of the individual becoming eligible for Medicaid benefits to begin the coordination and assessment process by the IACCT.

The LMHP must sign off on the CON for the TGH settings.

The team responsible for the plan of care shall include in PRTF, as a minimum must include:

1. A Board-eligible or Board-certified psychiatrist; or
2. A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist; and
3. The team shall also include one of the following: LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP. Upon the individual's enrollment into the Medicaid program, the residential treatment facility or IMD shall notify Magellan of Virginia of the individual's status as being under the care of the facility within five calendar days of the individual becoming eligible for Medicaid benefits to begin the coordination and assessment process by the IACCT.

The Psychiatrist must sign off on the CON for the PRFT settings.

Inpatient Transfer to Residential Services

1. Upon a member's admission to an inpatient facility, the facility will assess for viable discharge treatment options and develop an initial discharge plan.
2. If residential services are recommended as an option for the discharge plan, the inpatient facility will submit an online residential inquiry form to Magellan of Virginia within one business day. Alternatively, this form can be completed telephonically with Magellan of Virginia during a concurrent review.
3. When the legal guardian gives permission to move forward with the residential referral, Magellan of Virginia will contact the IACCT LMHP to begin the IACCT assessment process. The IACCT LMHP will schedule a face-to-face or telemedicine assessment (expedited, if possible), and will coordinate with the inpatient facility to gather any diagnostic and clinical assessments that were completed during the member's inpatient treatment.
4. If the member is clinically stable enough to return to the community during the IACCT assessment process, the inpatient facility will arrange community-based services to maintain member's stability during IACCT process.
5. If the member is not clinically stable enough to return to the community during the IACCT assessment process, the inpatient facility will complete the certificate of need and engage in an acute discharge planning process.

Additional information about the IACCT process is available on the Magellan of Virginia website at: Residential Service Changes.

Questions about the IACCT process may be directed by email to: RTCChange@dmas.virginia.gov.

Psychiatric Residential Treatment Facility Covered Services (RTS)

Psychiatric Residential Treatment Facility Covered Services

PRTF services are a 24-hour, supervised, clinically and medically necessary out-of-home program designed to provide necessary support and address mental health, behavioral, substance use, cognitive, or other treatment needs of a youth in order to prevent or minimize the need for more

intensive inpatient treatment. Active treatment and comprehensive discharge planning shall begin prior to admission. In order to be covered for youth, these services shall meet DMAS approved psychiatric medical necessity criteria or be approved as an EPSDT service, based upon a diagnosis made by an LMHP, LMHP-R, LMHP-RP, or LMHP-S who is practicing within the scope of their license; and be reflected in provider records and on the provider's claims for services by recognized diagnosis codes that support and are consistent with the requested professional services. Failure to perform any of the covered services as described below up until the discharge of the youth shall result in a retraction of the per diem and all other contracted and coordinated service payments for each day of non-compliance.

PRTF services are therapeutic services provided under the direction of a physician and shall include assessment and re-assessment; room and board; daily supervision; treatment planning; family engagement; therapeutic passes; crisis management; individual, family, and group therapy; care coordination; interventions; general or special education (not covered by the Medicaid program); medical treatment (including medication, coordination of necessary medical services, and 24-hour onsite nursing availability); specialty services; and discharge planning that meets the medical and clinical needs of the youth.

PRTF Service Requirements

The following clinical activities shall be required for each PRTF resident:

1) A face-to-face assessment shall be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 calendar days prior to admission and weekly thereafter, and shall document a DSM-5 or ICD-10 diagnosis.

2) A certificate of need shall be completed by the IACCT according to the requirements of 12VAC30-50-130(D)(4) or by the appropriate team in accordance with the emergency, retro, transfer or inpatient IACCT process. Please refer to the IACCT Appendix of this manual for details. Recertification by the team responsible for the CIPOC shall occur at least every 30 calendar days and be approved by a physician acting within their scope of practice.

3) The initial plan of care (IPOC) shall be completed within 24 hours of admission by the treatment team. The initial plan of care shall include:

a. Signature and date by the youth, parent, or legally authorized representative, a physician and treatment team members.
b. Plans for discharge; and
c. plans for continuing care, including review and modification to the plan of care;
d. any orders for medications, psychiatric, medical, dental, and any special healthcare

needs, whether or not provided in the facility, education or special education, treatments, interventions, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the youth;

e. Treatment objectives with short-term and long-term goals;
f. A description of the functional level of the youth;
g. diagnoses, symptoms, complaints, and complications indicating the need for admission;
h. Youth and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

4) The CIPOC shall be completed no later than 14 calendar days after admission by the treatment team. This information shall be used when considering changes and updating the CIPOC. The CIPOC shall meet all of the following criteria:

a.

b. Describe comprehensive transition plans and coordination of current care and post-discharge plans with related community services to ensure continuity of care upon discharge with the youth's family, school, and community.
c. Prescribe an integrated program of therapies, interventions, activities, and experiences designed to meet the treatment objectives related to the youth and family treatment needs; and
d. Shall state treatment objectives that shall include measurable, evidence-based, short-term and long-term goals and objectives, family engagement activities, and the design of community-based aftercare with target dates for achievement;
e. Be developed by an interdisciplinary team of physicians and other personnel specified in

12VAC30-50-130 and described further below who are employed by, or provide services to the youth in the facility in consultation with the youth, family member, or legally authorized representative, or appropriate others into whose care the youth will be released after discharge;

f. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the youth's situation and must reflect the need for PRTF care;

5.

5. The CIPOC shall be reviewed every 30 calendar days by the team responsible for the CIPOC to determine that services being provided are or were required from a PRTF and to recommend changes in the plan as indicated by the youth's overall adjustment during the time away from home. The CIPOC shall include the signature and date from the youth, parent, or legally authorized representative, a physician and treatment team members.

The "treatment team" developing the CIPOC shall meet the following requirements:

a.

a. The team shall also include one of the following: an LMHP, LMHP-S, LMHP-R, LMHP-RP

1. a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a licensed clinical psychologist.
2. a licensed clinical psychologist and a physician licensed to practice medicine or osteopathy; or
3. a board-eligible or board-certified psychiatrist;

b. The team shall include either:
c. At least one member of the team must have expertise in pediatric behavioral health. Based on education and experience, preferably including competence in child and adolescent psychiatry, the team must be capable of all of the following: assessing the youth's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the youth's family or legally authorized representative; setting treatment objectives; and prescribing therapeutic modalities to achieve the CIPOC's objectives.

6) Individual therapy shall be provided three times per week (or more frequently based upon the youth's needs) by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in the IPOC and CIPOC and progress notes in accordance with the requirements in this manual. A week is defined as Sunday through Saturday.

7) Group therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in the IPOC and CIPOC and progress notes in accordance with the requirements in this manual.

8. Family engagement shall be provided in addition to family therapy/counseling. To promote and prepare the youth and family for reunification, family engagement shall be provided at least weekly as outlined in the IPOC and CIPOC and daily communication with the family or legally authorized representative shall be part of the family engagement strategies in the IPOC and CIPOC.
9. Family therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in the IPOC and CIPOC and progress notes in accordance with the youth and family or legally authorized representative's goals and the requirements in this manual.

For each service authorization period when family engagement is not possible, the PRTF shall identify and document the specific barriers to the youth's engagement with his family or legally authorized representatives. The PRTF shall document on a weekly basis, the reasons why family engagement is not occurring as required. This information will be required on the updated service authorization form for these services. The PRTF shall document alternative family engagement

strategies to be used as part of the interventions in the CIPOC and include documentation of the revised CIPOC for review at the next service authorization submitted to Magellan of Virginia. The PRTF shall develop individualized family engagement strategies and document the revised strategies in the CIPOC. The revised CIPOC should include documentation of instances where family engagement did not occur.

In instances where the family or legal guardian has disengaged from treatment and routinely not participating in the weekly family engagement activities, the facility should document the communication and care coordination with the youth's Local Department of Social Services (LDSS) Worker.

Transportation benefits may be used to support family engagement. The PRTF is encouraged to contact the DMAS designated transportation contractor for assistance in coordinating services. Refer to the Transportation section in this chapter for more coverage information.

10) Three non-psychotherapy interventions shall be provided per 24-hour period including nights and weekends in addition to individual, group and family therapies as specified in the IPOC or CIPOC. Family engagement activities are considered to be an intervention and shall occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Daily interventions are not required when there is documentation to justify clinical or medical reasons for the youth's deviations from the service plan. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the IPOC and CIPOC. Any deviation from the IPOC or CIPOC shall be documented along with a clinical or medical justification for the deviation based on the needs of the youth.

11) Therapeutic passes shall be provided as clinically indicated in the plan of care and as paired with community and facility-based interventions and therapeutic services to promote discharge planning, community integration, and family engagement. Therapeutic passes should consist of collaboration with the family, legal guardian and/or supportive adults and involve consideration for what is clinically appropriate for the youth and family within the family's structure, culture and goals for engagement with the youth as they receive residential services.

The provider shall document how the family was prepared for the therapeutic pass to include a review of the plan of care goals and objectives being addressed by the planned interventions and the safety and crisis plan in effect during the therapeutic pass. Preparing the youth and the family for the therapeutic pass includes a meeting with the youth and the family in which the facility staff (i) reviews CIPOC goals and objectives for the pass; (ii) develops and reviews the safety and crisis plan that will be in effect while the youth is on the pass; (iii) instructs the youth, family, and facility staff on what skills learned during therapy will be practiced and applied during the pass; (iv) if facility staff will not be accompanying the youth on the pass, the facility staff will instruct the youth and the

family that the facility will contact the youth and the family on a daily basis during the pass, and that the facility is on-call to answer questions and concerns that the youth or the family may have during the pass; and (v) instructs the youth and the family that there will be a family meeting at the conclusion of the pass to review treatment plan and recovery related accomplishments and challenges that arose during the pass.

- The family meeting at the conclusion of the therapeutic pass will involve a discussion of the accomplishments and challenges during the pass, as well as progress or lack of progress toward CIPOC goals and objectives, and any needed updates to the CIPOC. The family meeting shall occur no later than seven calendar days from the end date of the therapeutic pass. In the event that a family therapy session is needed to address any issues that arose during the pass, facility staff will schedule a family therapy session as soon as possible.
- Activities that occur during the pass are individualized and based upon what skills were learned during individual, group, family therapy, and daily therapeutic services and set forth in the CIPOC goals and objectives for the pass. Facility staff may accompany the youth to the family home during the pass, if indicated in the CIPOC, to assist the youth and the family with practicing and applying skills learned during therapy. If a facility staff member does not accompany the individual on the therapeutic pass and the therapeutic pass exceeds 24 hours, the provider shall make daily contacts with the family and be available 24 hours per day to address concerns, incidents, or crises that may arise during the pass.

Twenty-four therapeutic passes shall be permitted per youth, per admission, without authorization as approved by the treating physician and documented in the CIPOC. Additional therapeutic passes shall require service authorization and can be requested during continued authorization requests. Any unauthorized therapeutic passes shall result in retraction for those days of service.

One pass equals any instance of time away from the facility campus to include short trips such as dinner with family or guardians and passes that include overnight stays at home.

12) A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and

referral to a substance use disorder provider is considered.

13) Discharge planning. Beginning at admission and continuing throughout the youth's placement at the PRTF, the parent or legally authorized representative, the Community Services Board (CSB), FAPT case manager, if applicable, and either the MCO or Magellan of Virginia care manager shall be involved in treatment planning and shall identify the anticipated needs of the youth and family upon discharge and identify the available services in the community.

Prior to discharge, the PRTF shall complete a comprehensive discharge plan in the CIPOC and submit the updated plan to Magellan of Virginia for review with its service authorization request. Once Magellan of Virginia approves the discharge plan, the provider shall begin collaborating with the parent or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for comprehensive needs assessments as needed The PRTF shall request information from post-discharge providers to establish that the planning of services and activities has begun, shall establish that the youth has been enrolled in school, and shall provide Individualized Education Program (IEP) recommendations to the school if necessary.

The PRTF shall inform Magellan of Virginia of all scheduled appointments within 30 calendar days of discharge, and shall notify Magellan of Virginia within one business day of the youth's discharge date from the PRTF. Failure to notify Magellan of Virginia of discharges can delay or prevent the youth from accessing needed medical, behavioral health, dental and pharmacy benefits and prevents Magellan from engaging in coordination of care upon discharge. Youth cannot have service authorizations for both PRTF and TGH at the same time and a delay in notifying Magellan of Virginia of a PRTF discharge for a youth who is transitioning to TGH will delay the service authorization for TGH.

PRTF Medical Necessity Criteria

The following admission criteria requirements for severity of need and intensity and quality of service shall be met to satisfy the criteria for admission:

Severity of Need

The following criteria shall be met to satisfy the criteria for severity of need.

(a) There is clinical evidence that the youth has a DSM-5 disorder that is amenable to active psychiatric treatment.

(b) There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

(c) Either

(i) there is clinical evidence that the youth would be at risk to self or others if he or she were not in a PRTF, or

(ii) as a result of the youth's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

(d) The youth requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow the youth to live outside of a PRTF setting.

(e) The youth's current living environment does not provide the support and access to behavioral health services needed.

(f) The youth is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

Intensity and Quality of Service

The following criteria shall be met to satisfy the criteria for intensity and quality of service:

(a) The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric

evaluation.

(b) The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the youth to live outside of a PRTF setting.

(c) An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour nursing services availability. This plan includes:

(i) at least once-a-week psychiatric reassessments;

(ii) intensive family and/or support system involvement occurring at least once per week, or identifies valid reasons why such a plan is not clinically appropriate or feasible;

(iii) psychotropic medications, when used, are to be used with specific target symptoms identified;

(iv) evaluation for current medical problems;

(v) evaluation for concomitant substance use issues;

(vi) linkage and/or coordination with the youth's community resources, including the local school division and FAPT case manager with the goal of returning the youth to his or her regular social environment as soon as possible, unless contraindicated.

Continued Stay Criteria

The following criteria shall be met to satisfy the criteria for continued stay:

(a) Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

(i) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs);

(ii) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs);

(iii) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued PRTF treatment. Subjective opinions without objective clinical information or evidence are not sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

(b) There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the youth can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources, including the local school division and FAPT case manager as appropriate, and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

(c) There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the youth’s ability to return to a less-intensive level of care.

(d) The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion in (a) above and this is documented in weekly progress notes, written and signed by the provider.

(e) There is evidence of intensive family and/or support system involvement occurring at least once per week, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

(f) A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-PRTF resources including the local school division and FAPT case manager as appropriate.

(g) All applicable elements in "Admission Criteria" and "Intensity and Quality of Service Criteria" are applied as related to assessment and treatment, if clinically relevant and appropriate.

Discharge Criteria

Discharge shall occur if any of the following applies:

- the level of functioning has improved with respect to the goals outlined in the CIPOC and the youth can reasonably be expected to maintain these gains at a lower level of treatment;
- the youth no longer benefits from service as evidenced by absence of progress toward CIPOC goals for a period of 30 calendar days; or
- other less intensive services may achieve stabilization

Seclusion and Restraint

PRTFs must comply with federal requirements regarding restraint and seclusion. Providers should refer to 42 CFR § 483.350 – 483.376 for detailed information regarding definitions, the protection of youth; orders for the use of restraint or seclusion; consultation with the treatment team physician; monitoring of the youth in and immediately after restraint or seclusion; notification of the youth's parent or legal guardian; application of time out; post emergency safety intervention debriefings; medical treatment for injuries resulting from an emergency safety intervention; facility reporting; and, education and training of staff.

Each year providers must submit to Magellan of Virginia a signed letter of attestation from the Chief Executive Officer (CEO) of the facility stating that the facility is in compliance with the federal condition of participation for the use of restraint or seclusion in psychiatric residential treatment facilities. Detailed information regarding this requirement can be found in Chapter II of this manual.

The use of Seclusion and Restraint in an IMD shall be in accordance with 42 CFR § 483.350 through 42 CFR § 483.376.

Facilities must report each instance of restraint or seclusion as defined in 42 CFR §483.352 involving a resident to Magellan of Virginia within one business day of the occurrence.

Facilities must report any serious incident involving a resident to Magellan of Virginia within one business day of the occurrence.

Please submit the following information to Magellan of Virginia via fax (888-656-5396):

- Youth's name and Medicaid number;
- Facility name, address, and NPI number;
- Name(s) of staff members and ordering physician involved;

- Detailed description of the incident and the staff debriefing that occurred following the incident;

- Dates and location of the incident;

- Outcome, including all persons notified; and

- Current location of the youth.

Service Exclusions

- PRTF services may not be billed concurrently with any Community Mental Health Rehabilitative Services, with the following exception: Intensive In-Home Services for Children and Adolescents may be billed for up to seven days immediately prior to discharge from a PRTF, to transition the youth from the PRTF to home.

- Providers may not bill another payer source for any supervisory services including daily supervision and one-on-one support when provided as PRTF services.

- PRTF services do not include reimbursement for activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the youth.

Therapeutic Group Home Services (RTS)

THERAPEUTIC GROUP HOME SERVICES

TGH services for youth shall provide therapeutic services to restore, develop, or maintain appropriate skills necessary to promote prosocial behavior and healthy living including skills restoration, family living and health awareness, interpersonal skills, communication skills, community integration skills, coping skills and stress management skills. Therapeutic services also engage families and reflect family-driven practices that correlate to sustained positive outcomes post-discharge for youth and their family members. Therapeutic services may occur in group settings, in one-on-one interactions, or in the home setting during a therapeutic pass. Each component of TGH services is provided for the direct benefit of the youth, in accordance with the youth's needs and treatment goals identified in the IPOC and CIPOC, and for the purpose of assisting in the youth's recovery. TGH services are provided under 42 CFR § 440.130(d) in accordance with the rehabilitative services benefit. Treatment for substance use disorders shall be addressed as clinically indicated.

Failure to perform any of the items described in the service requirements section below shall result in a retraction of the per diem for each day of non-compliance.

TGH Service Requirements

The following clinical activities shall be required for each TGH resident:

1) An assessment shall be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S upon admission.

2) A face-to-face evaluation shall be performed by an LMHP, LMHP-R, LMHP-RP or LMHP-S within 30 calendar days prior to admission with a documented DSM-5 or ICD-10 diagnosis.

3) A certificate of need shall be completed by the IACCT according to the requirements of 12VAC30-50-130, or by the appropriate team in accordance with the emergency, retro, transfer or inpatient IACCT process. Please see the IACCT supplement to this manual for additional information. Recertification shall occur at least every 60 calendar days by a LMHP, LMHP-R, LMHP-RP, or LMHP-S acting within their scope of practice.

4) An IPOC that is specific to the youth's unique treatment needs and acuity levels shall be completed on the day of admission by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall include all of the following: (i) youth and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance; (ii) diagnoses, symptoms, complaints, and complications indicating the need for admission; (iii) a description of the functional level of the youth; (iv) treatment objectives with short-term and long-term goals; (v) orders for medications, psychiatric, medical, dental and any special healthcare needs whether or not provided in the facilities, treatments, restorative and rehabilitative services, activities, therapies, therapeutic passes, social services, community integration, diet, and special procedures recommended for the health and safety of the youth; (vi) plans for continuing care, including review and modification to the plan of care; and (vii) plans for discharge. The IPOC shall be signed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the youth and a family member or legally authorized representative.

5) The CIPOC shall be completed no later than 14 calendar days after admission and shall meet all of the following criteria: (i) be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the youth's situation and shall reflect the need for TGH care; (ii) be based on input from school, home, other healthcare providers, FAPT if necessary, the youth, and the family or legal guardian; (iii) shall state treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement; (iv) prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and (v) include a comprehensive discharge plan with clear action steps and target dates including necessary, clinically appropriate community services to ensure continuity of care upon discharge with the youth's family, school, and community.

6) The CIPOC shall be reviewed, signed, and dated every 30 calendar days by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the youth or a family member or primary caregiver. The review shall include all of the following: (i) the youth's response to the services provided; (ii) recommended changes in the plan as indicated by the youth's overall response to the CIPOC interventions; and (iii) determinations regarding whether the services being provided continue to be required. Updates shall be signed and dated by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the youth or a family member or legally authorized representative.

7) Crisis management, clinical assessment, and individualized therapy shall be provided as indicated in the IPOC and CIPOC to include both mental health and substance use disorder needs as indicated in the IPOC and CIPOC to address intermittent crises and challenges within the TGH setting or community settings as defined in the plan of care and to avoid a higher level of care.

8) Care coordination shall be provided with medical, educational, and other behavioral health providers and other entities involved in the care and discharge planning for the youth as included in the IPOC and CIPOC; The facility/group home shall coordinate necessary services and discharge planning with other providers as medically and clinically necessary. Documentation of this care coordination shall be maintained by the facility or group home in the youth's record. The documentation shall include who was contacted, when the contact occurred, what information was transmitted and recommended next steps.

9) The program shall include individualized activities provided in accordance with the IPOC and CIPOC including a minimum of one non-psychotherapy intervention per 24-hour period in addition to individual, group, and family therapies as specified in the IPOC and CIPOC.

- Daily interventions are not required when there is documentation to justify clinical or medical reasons for the youth's deviations from the service plan.
- Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the IPOC and CIPOC.
- Any deviation from the IPOC or CIPOC shall be documented along with a clinical or medical justification for the deviation in the progress note.

10) Weekly individual therapy shall be provided in the TGH, or other settings as appropriate for the youth's needs, by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the definition of the term "progress note" in 12VAC30-60-61. A week is defined as Sunday through Saturday.

11) Group therapy shall be provided at a minimum of weekly and as documented in the IPOC or CIPOC by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, and shall be documented in progress notes in accordance with the definition of the term "progress note" in 12VAC30-60-61.

12) Family involvement begins immediately upon admission to the TGH. Family therapy shall be provided as clinically indicated and as documented in the IPOC or CIPOC by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in progress notes in accordance with the definition of the term "progress note" in 12VAC30-60-61. One family therapy session per week is recommended.

13) Family engagement activities shall be provided in addition to family therapy. To promote and prepare the youth and family for reunification, family engagement activities shall be provided at least weekly as outlined in the IPOC and CIPOC and daily communication with the family or legally authorized representative and the treatment team representative shall be part of the family engagement strategies in the IPOC or CIPOC.

For each service authorization period when family engagement is not possible, the TGH provider shall identify and document the specific barriers to the youth's engagement with his family or legally authorized representatives. At each treatment team meeting the facility team should be actively discussing the family involvement and planning for family engagement strategies. The TGH provider shall document on a weekly basis, the reasons why family engagement is not occurring as required. This information will be required on the updated service authorization form for these services. The TGH provider shall document alternative family engagement strategies to be used as part of the interventions in the CIPOC and include documentation of the revised CIPOC for review at the next service authorization submitted to Magellan of Virginia. The TGH provider shall develop individualized family engagement strategies and document the revised strategies in the CIPOC. The revised CIPOC should include documentation of instances where family engagement did not occur.

In instances where the family or legal guardian has disengaged from treatment and routinely not participating in the weekly family engagement activities, the facility should document the communication and care coordination with the youth's Local Department of Social Services (LDSS) Worker.

Transportation benefits may be used to support family engagement. The TGH provider is encouraged to contact the DMAS designated transportation contractor for assistance in coordinating services. Refer to the Transportation section in this chapter for more coverage information.

14) Therapeutic passes shall be provided as clinically indicated in the IPOC and CIPOC, and as paired with

facility- and community-based interventions to promote discharge planning, community integration, and family engagement activities. The provider shall document how the family was prepared for the therapeutic pass to include a review of the plan of care goals and objectives being addressed by the planned interventions and the safety and crisis plan in effect during the therapeutic pass. Preparing the youth and the family for the therapeutic pass includes a meeting with the youth and the family in which the facility staff (i) reviews ISP goals and objectives for the pass; (ii) develops and reviews the safety and crisis plan that will be in effect while the youth is on the pass; (iii) instructs the youth, family, and facility staff on what skills learned during therapy will be practiced and applied during the pass; (iv) if facility staff will not be accompanying the youth on the pass, the facility staff will instruct the youth and the family that the facility will contact the youth and the family on a daily basis during the pass, and that the facility is on-call to answer questions and concerns that the youth or the family may have during the pass; and (v) instructs the youth and the family that there will be a family meeting at the conclusion of the pass to review treatment plan and recovery related accomplishments and challenges that arose during the pass.

- Activities that occur during the pass are individualized and based upon what skills were learned during individual, group, family therapy, and daily therapeutic services and set forth in the IPOC and CIPOC goals and objectives for the pass. Facility staff may accompany the youth to the family home during the pass, if indicated in the IPOC and CIPOC, to assist the youth and the family with practicing and applying skills learned during therapy. If a facility staff member does not accompany the youth on the therapeutic pass and the therapeutic pass exceeds 24 hours, the provider shall make daily contacts with the family and be available 24 hours per day to address concerns, incidents, or crises that may arise during the pass.
- The family meeting at the conclusion of the therapeutic pass will involve a discussion of the accomplishments and challenges during the pass, as well as progress or lack of progress toward ISP goals and objectives, and any needed updates to the ISP. The family meeting shall occur no later than seven calendar days from the end date of the therapeutic pass. In the event that a family therapy session is needed to address any issues that arose during the pass, facility staff will schedule a family therapy session as soon as possible.

  Twenty-four therapeutic passes shall be permitted per youth, per admission, without authorization as approved by the treating LMHP, LMHP-R, LMHP-RP or LMHP-S and documented in the CIPOC. Additional therapeutic passes shall require service authorization and can be requested at the time of the continued service authorization. Any unauthorized therapeutic passes shall result in retraction for those days of service.

  One pass equals any instance of time away from the facility campus to include short trips such as dinner with family or guardians and passes that include overnight stays at home.

15) A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

16) Discharge planning. Beginning at admission and continuing throughout the youth's stay at the TGH, the family or guardian, the CSB, the FAPT case manager, and either the MCO or Magellan of Virginia care

manager shall be involved in treatment planning and shall identify the anticipated needs of the youth and family upon discharge and available services in the community. Prior to discharge, the TGH shall complete a comprehensive discharge plan in the CIPOC and submit the updated plan to Magellan of Virginia for review with its service authorization request. Once Magellan of Virginia reviews the discharge plan, the provider shall begin actively collaborating with the family or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for a comprehensive needs assessment as needed. The TGH shall request information from post-discharge providers to establish that the planning of pending services and transition planning activities have begun, shall establish that active transition planning has begun, the youth has been enrolled in school, and shall provide IEP recommendations to the school if necessary. The TGH shall inform Magellan of Virginia of all scheduled appointments within 30 calendar days of discharge, and shall notify Magellan of Virginia within one business day of the youth's discharge date from the TGH.

TGH Medical Necessity Criteria

The following admission criteria requirements for severity of need and intensity and quality of service shall be met to satisfy the criteria for admission:

Severity of Need

The following criteria shall be met to satisfy the criteria for severity of need:

(a) The youth's behavioral health condition can only be safely and effectively treated in a 24 hour therapeutic milieu with onsite behavioral health therapy due to significant impairments in home, school and community functioning caused by current mental health symptoms consistent with a DSM-5 diagnosis.

(b) The Certificate of Need must demonstrate all of the following:

(i) ambulatory care and Medicaid or FAPT-funded resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the youth;

(ii) proper treatment of the youth's psychiatric condition requires services on

an inpatient basis under the direction of a physician; and

(iii) the services can reasonably be expected to improve the youth's condition or prevent further regression so that the services will no longer be needed.

(c) An assessment which demonstrates at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. The state uniform assessment tool must be completed. A moderate impairment is evidenced by, but not limited to:

(i) frequent conflict in the family setting such as credible threats of physical harm. Frequent is defined as more than expected for the youth's age and developmental level;

(ii) frequent inability to accept age-appropriate direction and supervision from caretakers, family members, at school, or in the home or community;

(iii) severely limited involvement in social support, which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions;

(iv) impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community;

(v) limited ability to consider the effect of one's inappropriate conduct on others; and,

(vi) interactions consistently involving conflict, which may include impulsive or abusive behaviors.

(d) Less restrictive community based services have been given a fully adequate trial, and were unsuccessful or, if not attempted, have been considered, but in either situation were determined during the IACCT to be to be unable to meet the youth's treatment needs and the reasons for that are discussed in the certificate of need.

(e) The youth's symptoms, and/or the need for treatment in a 24/7 level of care, are not primarily due to any of the following:

(i) intellectual disability, developmental disability or autistic spectrum disorder;

(ii) organic mental disorders, traumatic brain injury or other medical condition; or

(iii) the youth doesn't require a more intensive level of care.

(f) The youth doesn't require primary medical or surgical treatment.

Intensity and Quality of Service

All of the following criteria shall be met to satisfy the criteria for intensity and quality of service.

(a) TGH service has been prescribed by a psychiatrist, psychologist, or other LMHP, LMHP-R, LMHP-RP or LMHP-S who has documented that a residential setting is the

least restrictive clinically appropriate service that can meet the specifically identified treatment needs of the youth.

(b) The TGH service is not being used for clinically inappropriate reasons, including:

(i) an alternative to incarceration, and/or preventative detention;

(ii) an alternative to parents', guardian's or agency's capacity to provide a place of residence for the youth; or

(iii) a treatment intervention, when other less restrictive alternatives are available.

(c) The youth's treatment goals are included in the IPOC and CIPOC and include behaviorally defined objectives that require, and can reasonably be achieved within, a TGH setting.

(d) The TGH is required to coordinate with the youth's community resources, including schools and FAPT as appropriate, with the goal of transitioning the youth out of the program to a less restrictive care setting with continued, services as soon as possible and appropriate.

(e) The TGH program must incorporate nationally established, evidence based, trauma informed services and supports that promote recovery and resiliency.

Continued Stay Criteria

The following criteria shall be met in order to satisfy the criteria for continued stay.

(a) All of the admission guidelines continue to be met and continue to be supported by the written clinical documentation.

(b) The youth shall meet one of the following:

(i) the desired outcome or level of functioning has not been restored or improved, in the time frame outlined in the youth's IPOC and CIPOC or the youth continues to be at risk for relapse based on history; or

(ii) the nature of the functional gains is tenuous and use of less intensive services will not achieve stabilization.

(c) The youth shall meet one of the following:

(i) the youth has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care;

(ii) the youth is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care;

(iii) the youth is not making progress, and the CIPOC has been modified to identify more effective interventions;

(iv) there are current indications that the youth requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic passes.

(d) There is a written, up-to-date discharge plan that:

(i) identifies the custodial parent or custodial caregiver at discharge;

(ii) identifies the school the youth will attend at discharge, if applicable;

(iii) includes IEP and FAPT recommendations, if necessary;

(iv) outlines the aftercare treatment plan (discharge to another residential LOC is not an acceptable discharge goal); and

(v) lists barriers to community reintegration, and progress made on resolving these barriers since last review.

(e) The CIPOC includes structure for daily therapeutic services, psycho-education, and therapeutic supervision and activities to ensure the attainment of therapeutic mental health goals as identified in the CIPOC.

(f) There is evidence of intensive family or support system involvement occurring at least once per week, unless there is an identified valid reason why it is not clinically appropriate or feasible.

(g) Less restrictive treatment options have been considered, but cannot yet meet the youth's treatment needs. There is sufficient current clinical documentation/evidence to show that TGH LOC continues to be the least restrictive level of care that can meet the youth's mental health treatment needs.

Discharge Criteria

Reimbursement shall not be made for this level of care if any of the following discharge criteria applies:

- the level of functioning has improved with respect to the goals outlined in the CIPOC and the youth can reasonably be expected to maintain these gains at a lower level of treatment; or

- the youth no longer benefits from service as evidenced by absence of progress toward CIPOC goals for a period of 60 calendar days.

- less intensive services may achieve stabilization.

Service Exclusions

1. Room and board costs shall not be reimbursed. Facilities that only provide independent living services or non-clinical services that do not meet the requirements of this manual are not eligible for reimbursement.
2. TGH services shall not be covered when treatment goals are met or less intensive services may achieve stabilization.
3. Services that are based upon incomplete, missing, or outdated assessments, IPOCs or CIPOCs shall be denied reimbursement.
4. TGH services may not be billed concurrently with any Community Mental Health Rehabilitative Services (CMHRS), with the following exceptions:

- Intensive In-Home Services for Children and Adolescents may be billed for up to seven days immediately prior to discharge from a TGH, to transition the youth from the TGH to home, as applicable.
- School based Therapeutic Day Treatment.
- Mental Health Skill-Building (MHSS) with the following limitations: the TGH may not serve as the MHSS provider for individuals residing in the provider's respective facility; MHSS is limited to 8 units per week, with at least half of each week's services

provided outside of the TGH; MHSS is limited to a maximum of 2 units per day; and, the MHSS Individual Service Plan (ISP) shall not include activities that contradict or duplicate those in the treatment plan established by the TGH. Limits may be exceeded based on medical necessity under EPSDT. See Chapter IV of the CMHRS Manual for additional details.

Early Periodic Screening, Diagnosis and Treatment (RTS)

Residential Treatment Facility and Therapeutic Group Home Services

Background Discussion

The EPSDT program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT fosters the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly and has more of an impact on the individual and the family. Examination and treatment services are provided at no cost to the Medicaid member.

Federal law requires that any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by the Department of Medical Assistance Services (DMAS) or its agent as medically necessary for the specific individual.

EPSDT Service Definition

EPSDT residential treatment services includes, but is not limited to clinically directed programming including applied behavior analysis and other evidence based/evidence informed behavior modification models. Services are designed to enhance communication skills and decrease maladaptive patterns of behavior which, if left untreated, could lead to more complex problems and the need for a greater or a more restrictive level of care. The service goal is to ensure the individual and family becomes able to more effectively manage the individual's behavior using behavioral modification strategies.

EPSDT residential treatment services shall focus on increasing adaptive behavioral function in communication skills, managing safety and aggressive behaviors, assessment and training in activities of daily living is also provided if the skill deficit impacts the clinical treatment needs of the individual.

EPSDT residential treatment services are intended to be a temporary rehabilitative, structured environment that fosters the use of evidence based behavioral strategies such as applied behavioral analysis and other evidence informed behavior modification strategies. EPSDT residential treatment services are expected to increase appropriate social - communicative interactions and pivotal responses within a social framework, increase adaptive functioning and produce beneficial changes in pivotal responses that result in more widespread behavioral change across a number of other non-targeted behaviors.

Treating service providers authorized to deliver medically necessary EPSDT services in therapeutic group homes, and residential treatment facilities on behalf of a Medicaid-enrolled individual shall adhere to the individualized interventions and evidence based progress measurement criteria described in the CIPOC and approved for reimbursement by DMAS, the DMAS contractor, or Magellan of Virginia.

All service requirements including but not limited to independent certification team, interventions, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT residential treatment, or therapeutic group home services.

The psychiatric, psychological and behavioral therapies that the individual requires must have clinical oversight from a licensed physician, psychiatrist, neurologist, licensed clinical social worker, licensed professional counselor, psychologist, or licensed behavior analyst along with coordination between other facility-employed or contracted licensed professionals in the fields of speech pathology, occupational therapy and physical therapy or audiology.

EPSDT Residential Treatment Services are not appropriate for children who have attained behavioral control and who only require services such as social skills enhancement.

EPSDT Eligibility Criteria for Residential Treatment Services

EPSDT Residential Treatment Services may be provided to persons with developmental delays such as autism and intellectual disabilities. Children must exhibit intensive behavioral challenges to be authorized for services.

- EPSDT Residential Treatment services are available to individuals who: are under 21 years of age and enrolled in Medicaid.

- EPSDT Residential Treatment services for Medicaid eligible children with developmental disabilities are service authorized and billed through Magellan of Virginia.

Covered Services

- Behavioral modification services to increase the individual's adaptive functioning and communication skills;
- Training of family members to improve the child's adaptive skills in the home and community;
- Care coordination;
- Assessment and behavior analysis encounters are permitted to be billed separately to the per diem reimbursement as noted earlier in the chart earlier in this chapter for services provided under arrangement, provided that the requirements discussed in this section are met;
- Behavioral modification services and direct consultation by the Licensed Behavior Analyst (LBA) or LBA - Assistant with direct services staff, and other professionals and paraprofessionals involved in the child's overall treatment and/or implementation of the behavior modification plan;
- Documentation and analysis of quantifiable behavioral data related to treatment objectives;
- Assistive technology related services (such as instruction or training on use of assistive technology or development of communication methods and materials related to the functional use of assistive communication and assistive technology devices);

Service Requirements

EPSDT residential treatment services must follow the service requirements/clinical intervention requirements as defined in the PRTF and TGH sections of this manual.

Ancillary services such as assessment and counseling will be delivered using evidence based and evidence informed treatment approaches specific to the needs of the individual receiving the residential treatment service. Specific reimbursement coding options are **available on the Magellan of Virginia website at: Process Changes: Psychiatric Residential Treatment Facility.**

Questions about the EPSDT services may be directed by email to: RTCChange@dmas.virginia.gov.

Limitations

- All services require authorization for reimbursement.

- Certain EPSDT DD Waiver Services are not allowed simultaneously with EPSDT

Medical Necessity Criteria for EPSDT
PRTF Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for severity of need.

A. There must be a diagnosed developmental disability and mental health condition that is amenable to active psychiatric treatment and behavioral modification strategies and behavioral supports.

"Developmental disability" means a severe, chronic disability of an

individual that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the individual attains age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in 3 or more of the following areas of major life activity: (a) self-care; (b)receptive and expressive language; (c) learning; (d) mobility; (e) self- direction; (f) capacity for independent living; (g) economic self-sufficiency; and (5) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. 42 U.S.C. § 15002.

B. There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

C. There is clinical evidence that the individual would be at risk to self or others if he or she were not in a residential treatment program,

D. The individual requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a residential treatment setting.

E. The individual's current living environment does not provide the behavioral support and access to therapeutic services needed.

F. The individual is medically stable but may require consistent medical management by a nursing team and needs this level of care to comply with behavioral health and / or healthcare treatment.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to- face psychiatric evaluation.

B. The program provides supervision and behavioral modification training and supports seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the individual to live outside of a structured residential setting or lower level of care.

C. An individualized plan of active psychiatric treatment, behavioral modification training/supports and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical and nursing service availability.

This plan includes:

1. at least once-a-week psychiatric reassessments;
2. intensive family and/or support system involvement occurring at least once per week; or identifies valid reasons why such a plan is not clinically appropriate or feasible;
3. psychotropic medications, when used, are to be used with specific target symptoms identified;
4. evaluation for current medical problems;
5. evaluation for concomitant substance use issues, and
6. linkage and/or coordination with the individual's community resources, including the local school division and FAPT case manager as appropriate, with the goal of returning the individual to his/her regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and

referral to a substance use disorder provider is considered.

Criteria for Continued Stay

Criteria A, B, C, D, E, F, and G must all be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic and supportive efforts, clinical and historical evidence indicates at least one of the following:
    a. the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), or
    b. the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), or
    c. that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness or functioning limitations to the degree that would necessitate continued residential treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical and behavioral functioning goals that must be met before the individual can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment and support resources (including housing) in anticipation of discharge, with alternative housing contingency plans also being addressed.

C. There is evidence that the treatment and behavioral support plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial and/or environmental stressors that are interfering with the individual's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and

this is documented in weekly progress notes, written and signed by the provider.

E. There is evidence of intensive family and/or support system involvement occurring at least once per week, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post- residential treatment resources including the local school division and FAPT case manager as appropriate.

G. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment/supports, if clinically relevant and appropriate.

Discharge Criteria

Continued residential level of care is not appropriate and will not be covered when one or more of the following exists.

A. The stabilization of presenting symptoms and behavioral/mental health conditions with demonstrated ability to function appropriate within residential environment and community setting.

B. The required treatment, Activity of Daily Living supports and behavioral supports can be provided in a less restrictive environment.

C. There is documented evidence, from the use of day and overnight pass that the individual has been able to function safely and satisfactorily with the community:

D. There has been no documented evidence of a change in treatment or behavioral support plan when the member has not responded for a 30 day period.

E. Reimbursement shall not be made for this level of care if any of the following applies:
    1. The level of functioning has improved with respect to the goals outlined in the CIPOC and the member can reasonably expected to maintain these gains at a lower level of treatment; or
    2. The member no longer benefits from services as determined by the oversight physician.

EPSDT Medical Necessity Treatment for TGH (RTS)

The child must require services from multiple disciplines. Behavioral modifications strategies must require the clinical oversight of a Licensed Mental Health Provider, or a Board Certified Behavioral Analyst.

Individuals must demonstrate deficits in adaptive functioning and require treatment services that cannot be provided by another DMAS program or lower level of care.

Severity of Need Criteria

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for severity of need.

A. There must be a diagnosed developmental disability and mental health condition that is amenable to active psychiatric treatment and behavioral modification strategies and behavioral supports.

    "Developmental disability" means a severe, chronic disability of an individual that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the individual attains age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in 3 or more of the following areas of major life activity: (a) self-care;

(b) receptive and expressive language; (c)learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; and (5) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. 42 U.S.C. § 15002.

B. There is a high degree of potential of the condition leading to acute psychiatric hospitalization or a higher level of care in the absence of therapeutic group home services.
C. There is clinical evidence that the individual would be at risk to self or others if he or she were not in a therapeutic group home.

D. The individual requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a therapeutic group home setting.

E. The individual's current living environment does not provide the behavioral support and access to therapeutic services needed.

F. The individual is medically stable but requires consistent clinical management by multidisciplinary team and needs this level of care to comply with behavioral health and / or healthcare treatment.

Admission Criteria (Must meet A-F):

A. The individual must demonstrate behaviors or symptoms which are expected to cause harm to self or others without immediate intervention.

B. The individual is medically stable, but needs systematic treatment interventions to increase adaptive behavioral functioning and increase communication abilities.

C. The individual's needs cannot be met in the home setting or a lower level of care because the behavioral modification strategies that were attempted in the home setting were not successful or the family members or caregivers are not able to or not willing to participate in the behavioral treatment process *and* it can be determined that the individual would be at risk for hospitalization or a higher level of care without such placement.

D. It has been documented that the individual would not achieve a demonstrable clinical or adaptive behavioral improvement if using similar treatment modalities in the home setting or within a less structured environment; The individual cannot be safely maintained or effectively treated at a less-intensive level of care.

E. These symptoms and behaviors present in increasing frequency, duration and intensity that require continual close monitoring and intervention by staff who are trained to treat individuals with DD/ASD in order to ensure member and milieu safety.

F. Therapeutic Group Home services must be reasonably be expected to increase the individual's functional autonomy or prevent regression so that the individual can engage with a lower level of care.

Admission - Intensity and Quality of Service

Criteria A, B, C, and D must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation.

B. The program provides supervision and behavioral modification training and supports seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the individual to live outside of

a structured residential setting or lower level of care.

C. An individualized plan of active psychiatric treatment, behavioral modification training/supports and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical and nursing service availability. This plan includes:

1. at least monthly psychiatric reassessments;
2. intensive family and/or support system involvement occurring at least once per week, or identifies valid reasons why such a plan is not clinically appropriate or feasible, and
3. psychotropic medications, when used, are to be used with specific target symptoms identified;
4. evaluation for current medical problems;
5. evaluation for concomitant substance use issues;
6. linkage and/or coordination with the individual's community resources, including the local school division and FAPT case manager as appropriate, with the goal of returning the individual to his/her regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

D. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Continued Stay Criteria (Must Meet All)

A. One of the following:

1. The desired outcome or level of functioning has not been restored or improved, in the time frame outlined in the member's CIPOC or the member continues to be at risk for relapse or regression based on history
2. The tenuous nature of the functional gains and use of less intensive services will not achieve stabilization.

B. One of the following:

1. The member has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care.
2. The member is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care.
3. The member is not making progress, and the CIPOC has been modified to identify more effective interventions.
4. There are current indications that the member requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a non-treatment residential setting or in a lower level of residential treatment.

C. As member makes progress evidenced by reduction in rates, intensity and duration of maladaptive behaviors and increase in skill acquisition, service authorization will reflect new presentation.

D. Coordination of care and discharge planning are ongoing with the goal of transitioning member to less intensive behavioral intervention and a less intensive level of care.

Discharge Criteria (Must Meet One)

Continued residential level of care is not appropriate and will not be covered when one or more of the following exists.

A. The stabilization of presenting symptoms and behavioral/mental health conditions with demonstrated ability to function appropriate within residential environment and community setting.

B. The required treatment, ADL supports and behavioral supports can be provided in a

less restrictive environment.

C. There is documented evidence, from the use of day and overnight pass that the individual has been able to function safely and satisfactorily with the community.

D. There has been no documented evidence of a change in treatment or behavioral support plan when the member has not responded for a 30 day period.

E. Reimbursement shall not be made for this level of care if any of the following applies:
    1. The level of functioning has improved with respect to the goals outlined in the CIPOC and the member can reasonably expected to maintain these gains at a lower level of treatment; or

    2. The member no longer benefits from services as determined by the oversight physician.

EPSDT 1:1 Services Criteria

- 1:1 Support is an intervention involving a specific level of monitoring for individuals who require one dedicated staff person to personally monitor one member in order to help ensure their health and safety.

- The treatment team must document the need for 1:1 support in the individualized assessment of the member. 1:1 supports must be included in the plan of care and be ordered by a physician.

- 1:1 supports may be appropriate in the following situations; when a member demonstrates:

    - Serious suicidal intent;

- The member verbalizes, gestures, or otherwise expresses an intent to inflict, or attempts to inflict, self-injury that would pose a threat to life;

- High risk for imminent attempts at elopement, evidenced by elopement attempt, or clear plan to elope;

- Severe physical aggression towards staff and/or other individual; active or recent homicidal threat to staff and/or other individuals; unpredictable physical aggression; or

- A severe health risk; the individual's behaviors are a severe health and safety risk to self or others. Accommodations (consisting of support for activities of daily living) for physical disabilities are not an appropriate use of 1:1 supports.

- The need for 1:1 supports must be reviewed at least weekly by the treatment team and the physician to determine if the member continues to meet criteria for this level of monitoring. Daily progress notes shall include the member's response to the intensive treatment supervision.

- The staff providing 1:1 supports must be no more than an "arm's length" away from the member at all times unless the individual is actively transitioning to a lesser level of supervision and 1:1 supports are "fading" as the individual transitions to a less intensive staffing ratio. The staff must not be performing any other duties or activities, and must not have any other assignments.

- Should the member continue to pose a threat to self or others, the treating physician needs to be notified. Member shall be assessed for possible acute hospitalization.

- 1:1 supports is not appropriate during nighttime hours if the member typically is

sleeping. However, staff continues to be responsible for monitoring member activity during any interrupted sleep.

- 1:1 supports are not reimbursed by EPSDT during school hours. The IPOC and CIPOC must identify how member's safety will be monitored during school hours.

- 1:1 supports will be authorized based on the individual needs of the member at the time of the authorization request.

Criteria for Discontinuing 1:1 Supports

1:1 Supports shall be discontinued if the following occurs:

- No incidences of severe physical aggression or homicidal threats in the previous 7 days.

- No attempts to elope in the previous 7 days.

- No serious attempts to harm self or others in the previous 7 days.

- No verbalization, gestures or expressions of intent to hurt self or others in the previous 7 days.

- Verbal or written safety contract between member and staff addressing issues which necessitated 1:1 supports is developed, dated and signed.

The provider must submit documentation supporting the need for continued 1:1 supports, an approximate schedule of 1:1 hours, the updated comprehensive plan of care, and a plan for reducing 1:1 hours. If the goals necessary to reduce or discontinue

supports are not met within the requested timeframe, the provider must provide documentation to support additional/continued hours which includes describing the barriers preventing the member from meeting their treatment goals.

- Special consideration should be given to individuals with Intellectual Disability, Autism Spectrum Disorder, and Developmental Delays who may require 1:1 support when their behavior, either intentional or unintentional, may cause harm to self or others as their ability to fully understand the potential injury that may result may be limited due to their intellectual functioning or communicative ability. Along with the request for 1:1 support, a plan must be provided to further assess the function of the behaviors to provide behavioral modification or evaluation of other medical needs, working toward reaching the least restrictive treatment environment for the member.